Instructions

These guidelines are offered to assist you in completing both the Plan and Budget (P and B) application and with the reporting requirements throughout the year. Please share them with appropriate staff.

Centers are required to report all client related services in the client and event data sets. The following information is provided to assist with some specific data set reporting and also to detail the information to be reported manually for those services that cannot be coded in the data set. Please refer to the Data Dictionary for specific service code descriptions.

Restricted mental health funding may be spread to a number of projects serving adults with serious mental illness (SMI) and those adults without SMI. Please complete the MH Financial Planning and Implementation Report (Form 117) indicating the programs and projects being supported with these funds and the corresponding amounts.

For SFY 2020, 100% of the adult allocation of Mental Health Block Grant funds, must be used for services described under the DIVERTS section of the contract, including the following Evidence-Based Practices for adults with serious mental illness: Assertive Community Treatment, Supported Employment, Supportive Housing, and Peer Support.

Also complete the Adult System of Care Application (Form 115). There ***should be a correlation between the system described in the Application and the programs being funded on the MH Financial Planning and Implementation Report (Form 117).***

Due with Plan and Budget	• Form 115 - Adult System of Care Application • Form 117 - MH Financial Planning and Implementation Report • Form 133A - PATH Intended Use Plan† • Form 133D - PATH Budget† • Form 119 – Youth and Young Adults System of Care Application

† If the Region has been awarded PATH Grant funds

The MH Financial Planning and Implementation Report (Form 117) must be submitted at initial submission of P and B as a planning document and quarterly to report actual expenditures.

Certain services also require additional reports as specified below.

Due Quarterly	• Form 101 - PATH PBFR† • Form 117 - MH Financial Planning and Implementation Report • Form 172 – Assertive Community Treatment • Form 173 – Peer Support • Form 174 – Supported Employment • Form 113H – Early Interventions for First Episode Psychosis iHOPE Project Report Form
Due Semi-Annually	• Form 113E – Deaf and Hard of Hearing Services Planning and Implementation Report

Flexible Funding for Adults with SMI who receive Targeted Case Management
Centers are required to set aside at least the amount allocated on their Notice of Available Regional Funding (NARF) for adult Flexible Funding and thus this amount should be reported on Form 117 at initial submission of P and B. Actual expenditures of Adult Flexible Funds for Individuals with SMI who receive TCM shall be reported on Form 117 quarterly. Service data should be reported in the Event Data Set using Service Code 25 (Miscellaneous Purchases).

Olmstead Flexible Funds Guidance (Regions 2, 6, 12, and 15)
Centers that serve as fiscal agents for these funds have responsibility for managing funds through cooperation with the Olmstead Transition Committee established in each state hospital district.

These allocations appear on the NARF and should be reported on Form 117 at initial P and B submission and quarterly thereafter.

Olmstead Flexible Funds- Expenditure Guidelines

Target Group
Olmstead Flexible Funds shall be used for individuals with SMI who meet the following Olmstead criteria:
- Treatment professionals determine that community treatment is appropriate;
- Affected persons are informed of options and do not oppose community treatment; and
- Placement can be reasonably accommodated taking into account the resources available to the state and others with mental disabilities.

And:
- Have resided in the hospital over 90 days; or
- Have had repeat admissions to the hospital over the course of one year and need flexible funding to remain in the community; or
- Reside in the Central KY Recovery Center and are ready for community placement.

Olmstead Transition Committee
Transition Committees at each state hospital that review cases and prioritize persons for the program include designated representatives of:
- The Kentucky Division of Behavioral Health;
- The state psychiatric hospital;
- The Regional Board who is the fiscal agent; and
- The Regional Board for the individual's community placement.

The committee may also include hospital discharge planners for the individuals and representatives of the community organizations who will serve them.

Input will be obtained from all committee members and consensus will be reached regarding appropriate services and allocation of Olmstead flexible funds.

Olmstead Transition Plans
A transition plan and cost analysis will be developed for each affected individual. The transition plan will be an extension of the hospital's discharge plan, with an emphasis on the preferences of the individual and a delineation of the services and supports that will be needed in the community. The transition plan will also address efforts to provide informed choice as to community living arrangements and choice of services.

Individual Budgets
Funds will be designated for the purchase of services and supports based on an individual treatment/recovery plan, and individual budgets will need to be prepared based on a menu of services. Typical services may include targeted case management, residential support, supported employment, therapeutic rehabilitation, assertive community treatment, peer support, comprehensive community supports, or medications.

These funds may not be used to pay for services that are available to the individual through an existing funding stream.

Interface with Continuity of Care Efforts

Continuity of care committees have been established by the Division of Behavioral Health to facilitate collaboration between state hospitals and their respective regional boards in relation to:

- Admission and discharge processes
- Continuity of care for outpatient appointments and medications
- Readmission rates

Continuity of care committees should be a resource for review of transition activities and their outcomes.

Olmstead Outcomes

A quarterly programmatic report should be submitted to the Transition Committee by the CMHC managing the funds. These reports will track basic outcomes concerning community tenure and progress of individual clients.

PATH Grant Funds (Regions 4, 6, 7, 12, 13 and 15)

Existing PATH providers will be awarded continuation funding subject to adjustment based on performance and the grant amount received by the state. In addition to state level reporting, an annual data report must be submitted on-line to the federal contractor for the PATH Program. Information on federal reporting requirements will be sent to the providers prior to or during the reporting period.

Additional Instruction for the Adult System of Care Application – Form 115

Housing Options Section:

Supportive Housing programs are defined as programs focused on working with individuals to choose, get and keep standard housing in the community. These programs typically utilize a case management model but may utilize Assertive Community Treatment for service provision. These programs are usually bolstered by a flexible housing assistance fund.

Residential Support is defined as projects that typically hire on-site staff in permanent housing settings owned and managed by local CMHC.

Housing Development is defined as programs that generate new housing options at the local level, with the CMHC building/constructing new units.

Additional Instruction for the MH Financial Planning and Implementation Report – Form 117

DIVERTS Spending Plan-The total DIVERTS funding amounts from the approved Notice of Available Regional Funding for SFY 2021. 1) DIVERTS (SGF) funding should be identified in Column D (RESTRICTED MH Funds-State and Agency). 2) Identify MHBG funds allocated for ACT, peer support, supportive housing and supported employment under DIVERTS in Column B (CMHS Federal MH Block Grant Funds).

DIVERTS Expenditure Reporting-As submitted on Form 117 Quarterly

1) Identify DIVERTS (state general funding) expenses in Column D for the appropriate quarter. 2) Identify MHBG (federal funds) expenses in Column B for the appropriate quarter. 3) Identify Year to Date DIVERTS expenses in Column F.

Note: DIVERTS funding and MHBG funding is considered "expense reimbursed" for SFY 2021 in that you will need to reconcile expenses at the end of the fiscal year and repay funds not expensed according to your approved line-item budget. You will continue to receive one-twelfth payments throughout the year as long as you are in compliance with terms outlined in your SFY 2021 CMHC contract.

DIVERTS Forms 172, 173, 174 – As submitted quarterly for reporting purposes
When reporting outcomes on forms for each Evidence Based Practice, please note the following guidelines: Individuals served as part of the Second Amended Settlement Agreement (SASA) are defined as the following: Adults with SMI who are transitioning from personal care homes or diverted from entry into a personal care home. DIVERTS individuals are defined as adults with SMI who are transitioning from hospitals/other institutions (not PCHs) or at risk of admission to a hospital/other institution (not PCHs), who are not being diverted from entry into a personal care home.

DIVERTS Form 173 Peer Support – As submitted quarterly for reporting purposes
When reporting outcomes on Form 173 for Peer Support, please see the following guidelines:

Individuals served or working in Consumer Operated Services Programs (COSP) should only be reported by regions who received Mental Health Block Grant funding from DBHDID to develop consumer run programs as described in the SAMHSA Consumer Operated Services Toolkit. (Please talk about other consumer run programming in the Form 115 document, but Form 173 is gathering outcomes on DBH funded COSP only);

In addition***, individuals working as peers on ACT teams should not be listed on the Peer Support Form 173, because they are to be captured on the ACT Form 172. Individuals who receive peer support through Assertive Community Treatment teams should not be reported on Form 173 for Peer Support (they are captured on the ACT form 172);***

Peer Support Supervisors should be listed with their name, title (licensure status), location, and should include the schedule (frequency) and type (individual or group or both) of supervision provided to peer specialists. Objective Statement 1 on Form 173 requests specific names, FTE status and location by program/population for all hired adult peer specialists.

EVIDENCE BASED PRACTICE DEFINITIONS

The intent of these guidelines is to provide guidance on EBPs. They are not intended to be prescriptive or to set inflexible boundaries, but to indicate whether the services being reported conform broadly to the evidence-based practices. As reporting takes place, these guidelines are expected to be revised and refined over time.

ASSERTIVE COMMUNITY TREATMENT

I. DEFINITION

A team based approach to the provision of treatment, rehabilitation and support services. ACT models of treatment are built around a self-contained, multi-disciplinary team that serves as the fixed point of responsibility for all behavioral health care for a fixed group of individuals. In this approach, normally used for individuals with serious mental illness who are at risk for repeat hospitalizations or recent homelessness, the treatment team typically provides most services using a highly integrated approach to care. Key aspects are low caseloads and the availability of the services in a range of settings. The service is a recommended practice in the PORT study (Translating Research Into Practice: The Schizophrenia Patient Outcomes Research Team (PORT) Treatment Recommendations, Lehman, Steinwachs and Co-Investigators of Patient Outcomes Research Team, Schizophrenia Bulletin, 24(1):1-10, 1998), as well as subsequent (PORT) studies reviewed and revised in 2003 and 2009, and was highlighted in the Surgeon General's Report on Mental Health (U.S. Department of Health and Human Services, 1999) as an effective service for people with Severe and Persistent Mental Illness. That same year, federal Centers for Medicare and Medicaid Services (formerly Health Care Financing Administration) issued an advisory letter to state governments that recommended state Medicaid agencies consider adding the service to their State Plans. The Substance Abuse and Mental Health Services Administration (SAMHSA), the agency primarily responsible for federal mental health services funding, determined that the presence of ACT services is one of the three indicators of the quality of a state's mental health system (Substance Abuse and Mental Health Services Administration, 2002). In collaboration with the Robert Wood Johnson Foundation, SAMHSA is also supporting the Evidence-Based Practices Project and the dissemination of ACT as one of the six evidenced-based practices (EBP) services.

II. FIDELITY MEASURE

https://store.samhsa.gov/product/Assertive-Community-Treatment-ACT-Evidence-Based-Practices-EBP-KIT/sma08-4345

III. MINIMUM REQUIREMENTS FOR REPORTING ACT

The intent of these guidelines is to provide guidance on evidence-based practices. They are not intended to be prescriptive or to set inflexible boundaries, but to indicate whether the services being reported conform broadly to the evidence-based practices.

- Small caseload: Client/provider ratio of 10:1 or fewer is the ideal.
- Multidisciplinary team approach: This is a team approach rather than an approach which emphasizes services by individual providers. The team should be multidisciplinary and should include a nurse, peer support specialist, clinician, substance abuse specialist, case manager, etc. For reporting purposes, there should be at least 4 FTE on the team, not counting prescribers and/or office managers.
- Includes clinical component: In addition to case management, the program directly provides services such as: counseling/psychotherapy, housing support, substance abuse treatment, employment/rehabilitative services. The program also provides flexible access to a prescriber for individuals served by ACT. The prescriber for the individual should be an accredited individual with sufficient experience and insight to assist the team in constructing a plan of care for each individual being served with this program.
- Services provided in community settings: Program works to monitor status, develop community living skills in the community rather than the office.
- Responsibility for crisis services: Program has 24-hour responsibility for covering psychiatric crises.

IV. ACT IS NOT INTENSIVE CASE MANAGEMENT

Note: If specific EBPs are provided as a component of ACT, they should be reported under ACT and not separately under other practices. (Please note that to report these as EBPs; they should conform to the reporting guidelines for each EBP provided in this document.)

SUPPORTED EMPLOYMENT

I. DEFINITION

Supported Employment (SE) is an evidence-based service to promote rehabilitation and retainment or return to productive employment for persons with serious mental illnesses. The Individual Placement and Support (IPS) model of Supported Employment helps people living with behavioral health conditions work at regular jobs of their choosing. Although variations of supported employment exist, IPS refers to the evidence based practice for individuals with serious mental illness. IPS SE programs should focus on each person's strengths, work towards promoting recovery and wellness, work in collaboration with vocational rehabilitation counselors, use a multidisciplinary approach, work to individualize services that last as long as the person needs and wants them, and work to change the way mental health services are delivered.

II. FIDELITY MEASURE

https://ipsworks.org/wp-content/uploads/2017/08/IPS-Fidelity-Scale-Eng1.pdf

III. MINIMUM REQUIREMENTS FOR REPORTING IPS SUPPORTED EMPLOYMENT

- Focus on Competitive Employment: Agencies providing IPS services are committed to competitive employment as an attainable goal for people with behavioral health conditions seeking employment. Mainstream education and specialized training may enhance career paths.

- Based on Individual Choice: People are not excluded on the basis of readiness, diagnoses, symptoms, substance use history, psychiatric hospitalizations, homelessness, level of disability, or legal system involvement.
- Integration of Rehabilitation and Mental Health Services: IPS programs are closely integrated with mental health treatment teams.
- Attention to Worker Preferences: Services are based on each person's preferences and choices, rather than providers' judgments.
- Personalized Benefits Counseling: Employment specialists help people obtain personalized, understandable, and accurate information about their Social Security, Medicaid, and other government entitlements.
- Rapid Job Search: IPS programs use a rapid job search approach to help job seekers obtain jobs directly, rather than providing lengthy pre-employment assessment, training, and counseling. If further education is part of their plan, IPS specialists assist in these activities as needed.
- Systematic Job Development: Employment specialists systematically visit employers, who are selected based on job seeker preferences, to learn about their business needs and hiring preferences.
- Time-Unlimited and Individualized Support: Job supports are individualized and continue for as long as each worker wants and needs the support.

IV. SUPPORTED EMPLOYMENT IS NOT:

- Prevocational training
- Sheltered work
- Employment in enclaves (that is in settings, where only people with disabilities are employed)
- [If an employment specialist is part of an ACT team, this should be reported under ACT and not separately as supported employment.]

SUPPORTIVE HOUSING

I. DEFINITION

Supportive Housing consists of services to assist individuals in finding and maintaining housing in the community. This activity is premised upon the provision of supportive services and assistance with residential responsibilities that enable persons with SMI to live independently in the community. These services assist consumers to select, obtain, and maintain safe, decent, affordable housing and maintain a link to other essential services provided within the community. The objective of supportive housing is to help obtain and maintain an independent living situation.

Supportive Housing is a specific program model in which a consumer lives in a house, apartment or similar setting, alone or with others, and has considerable responsibility for residential maintenance but receives periodic visits from mental health staff or family for the purpose of monitoring and/or assisting with residential responsibilities. Criteria identified for supportive housing programs include: housing choice, functional separation of housing from service provision, affordability, integration (with persons who do not have mental illness), and right to tenure, service choice, service individualization and service availability.

II. FIDELITY MEASURE

http://store.samhsa.gov/product/Permanent-Supportive-Housing-Evidence-Based-Practices-EBP-KIT/SMA10-4510

III. MINIMUM REQUIREMENTS FOR REPORTING SUPPORTIVE HOUSING

- Target population: Targeted to persons who would not have a viable housing arrangement without this service.
- Staff assigned: Specific staff are assigned to provide supportive housing services.
- Housing is integrated: Supportive housing is provided in settings that are also available to persons who do not have mental illnesses.
- Consumer has the rights of tenancy: The ownership or lease documents are in the name of the consumer.
- Affordability: Supportive housing assures that housing is affordable (consumers pay no more than 30-40% on rent and utilities) through adequate rent subsidies, etc.

IV. SUPPORTIVE HOUSING IS NOT:

- Residential treatment services or a component of targeted case management or Assertive Community Treatment.

ADULT PEER SUPPORT SERVICES

I. DEFINITION

Services provided by an adult peer support specialist to assist adults with serious mental illness (SMI) in achieving specific recovery goals identified by the individual receiving services as specified in the Treatment/Recovery plan, and provided under the direct supervision of one of the Medicaid approved professionals. (See Service Standards on website.) All peer support interventions are planned and implemented in a partnership that occurs between the individual receiving services and their behavioral health treatment team members. These services include:

a. Face-to-face interventions on an individual or group basis to provide structured, scheduled non-clinical but therapeutic activities that promote socialization, recovery, self-advocacy, and preservation and enhancement of community living skills;

b. Face-to-face interventions on an individual or group basis that assist individuals with getting in touch with meaningful life goals they would like to achieve; AND

c. Peer Support Services must be coordinated within the context of a comprehensive, individualized treatment/recovery plan which is developed through a person centered planning process. Peer Support must be identified on each individual treatment/recovery plan as an intervention and this intervention must be designed to directly contribute to the individualized goals and objectives, as specified in the plan.

II. FIDELITY MEASURE (Not applicable)

III. MINIMUM REQUIREMENTS FOR REPORTING PEER SUPPORT SERVICES

- Services are provided by a Certified Adult Peer Support Specialist.
- An Individual Treatment/Recovery Plan that identifies specific recovery goals and objectives has been developed.
- Services delivered, whether individual or group, are documented in the medical record.
- Adult Peer Support Specialists are supervised according to 908 KAR 2:220.

IV. PEER SUPPORT SERVICES ARE NOT:

- Activities engaged in by peers as part of regular program participation (e.g. cooking lunch at a therapeutic rehabilitation program, assisting in solely transporting individuals receiving services).

- Recreational or social activities led by peers as part of social-club drop-in or other consumer operated services programs (unless these activities are part of a participating individual's treatment/recovery plan).
- Volunteer (non-paid) activities that may be engaged in by Certified Adult Peer Support Specialists or other non-certified individuals with lived experience.

CONSUMER OPERATED SERVICES PROGRAM (COSP)

I. DEFINITION

A peer-run program that is administratively controlled and operated by individuals in recovery and emphasizes self-direction as the approach to assisting individuals in pursuing personal recovery. Consumer Operated Services Programs are generally staffed by individuals who have lived experience with behavioral health issues**.** These programs typically provide:

a. a safe and supportive environment, acceptance, and education
b. the sharing of personal stories to help others through mutual support
c. opportunities for individuals to develop new social and interpersonal networks
d. new ways of thinking about one's experience and practical ways to handle problems
e. an array of services and activities not limited to behavioral health treatment

Structural elements necessary for effective programs include:

a. control by individuals in recovery
b. membership-run activities (combination of paid and voluntary)
c. participatory leadership
d. voluntary participation

Process elements necessary for effective programs include:

a. belief systems that include empowerment, recovery beliefs and recovery practices
b. role structures that emphasize a variety of opportunities
c. social activities that include reciprocal relationships and is based on strengths
d. peer support (formal and informal)
e. education/advocacy

II. FIDELITY MEASURE

http://store.samhsa.gov/product/Consumer-Operated-Services-Evidence-Based-Practices-EBP-KIT/SMA11-4633CD-DVD

III. MINIMUM REQUIREMENTS FOR REPORTING COSP

- If providing formal (billable) peer support services, must code appropriately in client/event data set
- If providing formal (billable) adult peer support services, must follow 908 KAR 2:220
- If providing formal (billable) peer support, must follow peer support service standards
- Must keep track of number of people who attend the program each day

IV. CONSUMER OPERATED SERVICES PROGRAMS ARE NOT

- Therapeutic Rehabilitation Programs
- Illness, Management and Recovery Programs
- Social Club Drop-In Centers

ILLNESS MANAGEMENT AND RECOVERY (IMR)

I. DEFINITION:

IMR is a step-by-step program that gives people information and skills to help them set and achieve personally meaningful recovery goals. IMR can be provided in an individual or group format.

II. GOALS:

Goals of IMR are for individuals to:

- Make progress toward personal goals and toward recovery
- Learn about mental illness and strategies for treatment
- Decrease symptoms
- Reduce relapses and hospitalizations

III. COMPONENTS:

Components of IMR:

- IMR orientation session that reviews goals and expectations of the program
- Assistance in developing personal definitions of recovery
- Assistance in identifying and pursuing personal goals
- Approximately ten to twelve months of weekly sessions (or five to six months of twice-weekly sessions) using a series of educational handouts
- Active practice of skills during sessions and at home
- Involvement of significant others (with individual's permission) to increase their understanding and support
- At least one IMR wrap up session to help sum up progress and make plans for the future

IV. FIDELITY MEASURE

https://store.samhsa.gov/product/Illness-Management-and-Recovery-Evidence-Based-Practices-EBP-KIT/sma09-4463